Department of Human Services
Bureau of Human Service Licensing
LICENSING INSPECTION SUMMARY - PUBLIC

August 27, 2026

[redacted] ADMINISTRATOR
ALBRIGHT CARE SERVICES
[redacted]

RE: RIVERVIEW MANOR
130 MAGNOLIA DRIVE
LEWISBURG, PA, 17837
LICENSE/COC#: 20298

Dear [redacted]

As a result of the Pennsylvania Department of Human Services, Bureau of Human Service Licensing review on 06/11/2026 of the above facility, we have determined that your submitted plan of correction is fully implemented. Continued compliance must be maintained.

Please note that you are required to post this Licensing Inspection Summary at your facility in a conspicuous location.

Sincerely,
[redacted]

cc: Pennsylvania Bureau of Human Service Licensing

Facility Information

Name: *RIVERVIEW MANOR* **License #**: *20298* **License Expiration**: *05/19/2027*

Address: *130 MAGNOLIA DRIVE, LEWISBURG, PA 17837*

County: *UNION* **Region**: *NORTHEAST*

Administrator

Name: *Aaron Barth* **Phone**: *570-522-6232* **Email**: *aaron.barth@asbury.org*

Legal Entity

Name: *ALBRIGHT CARE SERVICES*

Address: *270 RIDGECREST CIRCLE, LEWISBURG, PA, 17837*

Phone: *5705226204* **Email**: *AARON.BARTH@ASBURY.ORG*

Certificate(s) of Occupancy

Type: *C-2 LP* **Date**: *12/12/1975* **Issued By**: *DLI*

Staffing Hours

Resident Support Staff: *0* **Total Daily Staff**: *40* **Waking Staff**: *30*

Inspection Information

Type: *Full* **Notice**: *Unannounced* **BHA Docket #**:

Reason: *Renewal* **Exit Conference Date**: *06/11/2026*

Inspection Dates and Department Representative

06/11/2026 - On-Site: Erin Diehl, Amy Deluca, Erin Madl

Resident Demographic Data as of Inspection Dates

General Information

License Capacity: *100* **Residents Served**: *38*

Secured Dementia Care Unit

In Home: *No* **Area**: **Capacity**: **Residents Served**:

Hospice

Current Residents: *3*

Number of Residents Who:

Receive Supplemental Security Income: *0* **Are 60 Years of Age or Older**: *38*

Diagnosed with Mental Illness: *0* **Diagnosed with Intellectual Disability**: *0*

Have Mobility Need: *2* **Have Physical Disability**: *0*

Inspections / Reviews

06/11/2026 Full

Lead Inspector: *Erin Diehl* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *07/17/2026*

07/28/2026 - POC Submission

Submitted By: *Aaron Barth* **Date Submitted**: *08/21/2026*

Reviewer: *Ryan Yankowy* **Follow-Up Type**: *POC Submission* **Follow-Up Date**: *08/04/2026*

Inspections / Reviews *(continued)*

08/13/2026 POC Submission

Submitted By: *Aaron Barth* **Date Submitted**: *08/21/2026*

Reviewer: *Ryan Yankowy* **Follow Up Type**: *Document Submission* **Follow Up Date**: *08/17/2026*

08/27/2026 Document Submission

Submitted By: *Aaron Barth* **Date Submitted**: *08/21/2026*

Reviewer: *Ryan Yankowy* **Follow Up Type**: *Not Required*

3c - Post Current License

1. Requirements

2600.
3.c. The personal care home shall post the current license, a copy of the current license inspection summary issued by the Department and a copy of this chapter in a conspicuous and public place in the personal care home.

Description of Violation

At approximately 9:25 a.m. the licensing inspection summaries dated 9/18/25 and 6/10/25 were not posted in a conspicuous place, they were found in a closed drawer in a stand in the lobby. There was no signage to indicate where the summaries could be found.

Plan of Correction ***Accept (- 08/13/2026)***

The current license, copy of license inspection summary, and copy of this chapter were placed prominently and visibly in the lobby by the Director of Nursing on 6/10/2026. Staff were educated on the required posting by the Director of Nursing on 6/11/2026. The Administrator will monitor the lobby for required posting. Additionally, the administrator will audit the posting and contents of the posting weekly for a period of three months and then monthly thereafter until substantial compliance is achieved. Results will be brought to regularly scheduled QAPI meetings.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented (- 08/27/2026)

25c2 - Fee Schedule

2. Requirements

2600.
25.c. At a minimum, the contract must specify the following:
2. A fee schedule that lists the specify the following: actual amount of allowable resident charges for each of the home's available services.

Description of Violation

Resident #2's contract signed does not contain a fee schedule for provided services.

Plan of Correction ***Accept (- 08/13/2026)***

Resident # 2 contract addendum with fee schedule was corrected on 6/11/2026 by the Administrator. The Sales Director and Lead Medication Technician were educated by the Administrator on 6/10/2026 on the importance of resident awareness regarding the required fee schedule and how to upload into the medical record. An audit of all resident records was conducted on 6/11/2026 by the Lead Medication Technician, no other corrections were necessary at that time. The administrator will audit all new resident records monthly for the appropriate fee schedule for a period of three months and then ongoingly thereafter until substantial compliance is achieved. Results will be brought to regularly scheduled QAPI meetings.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented (- 08/27/2026)

60a - Staff/Support Plan

3. Requirements

2600.
60.a. Staffing shall be provided to meet the needs of the residents as specified in the resident's assessment and support plan.

60a - Staff/Support Plan *(continued)*

Description of Violation

The home has 38 residents, 2 of which are 2 person assists, and 6 residents who require supervision when outside of the home and utilize a wander guard for their own safety. The home has 2 fire safe areas that are cut off from each other, 6 exits to the outside of the building and 2 exits to the Independent Living Area of the building, and allowed 10 minutes to evacuate. The home is currently scheduling 2 staff are schedule overnight from 10:00 p.m. to 6:30 a.m. The home is not scheduling enough staff to evacuate and monitor the residents for safety in the event of an emergency. The home has also not completed a sleeping hours fire drill with only 2 overnight staff scheduled.

Plan of Correction ***Accept ([redacted] - 07/28/2026)***

The 2 residents who were classified as 2-person assists are no longer residing in the home. All RASPs were reviewed on 7/8/2026 and there are no residents requiring a 2-person assist. Additionally, the 6 residents identified as receiving supervision via the Wanderguard system are able to evacuate safely during fire drills, as documented in their RASPs. Section E part 3 was reviewed on all resident RASPs to ensure compliance in this regard. Evacuation routes were evaluated and plans were devised to split resident assignments into 2 groups for situations where only 2 staff are on site. A fire drill was conducted on 7/12/2026 during the 10pm to 6:30am shift with only 2 staff present whereby the 10-minute evacuation requirement was met and all residents were safely evacuated.

Licensee's Proposed Overall Completion Date: *07/14/2026*

Implemented ([redacted] - 08/27/2026)

63a - First Aid/CPR Training

4. Requirements

2600.
63.a. At least one staff person for every 50 residents who is trained in first aid and certified in obstructed airway techniques and CPR shall be present in the home at all times.

Description of Violation

On 5/21/26 from 6:00 a.m. to 10:00 p.m. the home served 38 residents, and no staff were trained in First Aid and CPR. On 5/22/26 from 2:30 p.m. to 12:00 a.m. the home served 38 residents, and no staff were trained in First Aid and CPR. On 5/23/26 from 12:00 a.m. to 6:00 a.m. and then from 2:30 p.m. to 5/24/26 at 6:00 a.m. the home served 38 residents, and no staff were trained in First Aid and CPR.

Plan of Correction ***Accept ([redacted] - 08/13/2026)***

Training was conducted on 7/6/2026 and 7/8/2026 by a certified outsider vendor using American Heart Association training course. An audit of all staff records for First aid was conducted by the Lead Medication Technician on 7/8/2026. All staff who were non-compliant with First aid training have since completed training or have been removed from scheduled shifts in instances where other staff members also not yet trained in first aid. All new Hires and annual required updates for first aid will be monitored by Human Resources monthly for a period of three months and then ongoingly thereafter until substantial compliance is achieved. Results will be brought to regularly scheduled QAPI meetings.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented ([redacted] - 08/27/2026)

65g - Annual Training Content

5. Requirements

2600.
65.g. Direct care staff persons, ancillary staff persons, substitute personnel and regularly scheduled volunteers shall be trained annually in the following areas:
1. Fire safety completed by a fire safety expert or by a staff person trained by a fire safety expert. Videos prepared by a fire safety expert are acceptable for the training if accompanied by an onsite staff person trained by a fire safety expert.

Description of Violation

Staff Person B and Staff Person C did not receive training in Fire Safety by a Fire Safety Expert in Training Year 2025.

Plan of Correction ***Accept (- 08/13/2026)***

Administrator educated our Facilities Manager on the regulatory requirements for annual Staff Fire Safety Training on 6/10/2026. An audit was conducted by the Administrator on 6/10/2026 for 2026 fire safety training compliance. 2026 Staff trainings were completed over multiple blocks of time on Friday, July 31. Staff B & C completed their 2026 training as part of this process. Ongoingly, new hires will complete annual fire safety training during their orientation. Compliance will be monitored by the Personal Care Home Administrator at our regularly scheduled QAPI meetings.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented (- 08/27/2026)

81b Resident Personal Equipment

6. Requirements

2600.
81.b. Wheelchairs, walkers, prosthetic devices and other apparatus used by residents must be clean, in good repair and free of hazards.

Description of Violation

Resident #1 utilizes an enabler bar attached to their bed. At 2:30 p.m. there was an approximate six-inch gap between the enabler bar and the mattress. Also, the enabler bar was not attached securely to the bed frame and could easily be maneuvered in all directions.

Plan of Correction ***Accept (- 08/13/2026)***

Resident # 1 enabler bar was removed from the bed on 7/6/2026 by our Facilities Manager. The Facilities manager and the facilities staff team was educated by our therapy team on bed safety, including enabler bar securement and mattress gaps on 7/31/2026. An audit of all resident beds for enabler bars and mattress gaps was conducted on 7/6/2026, by our Director of Nursing. All other beds found to be compliant. Facilities manager &/or designee will audit bed safety for enabler bars and mattress gaps monthly for 3 months and then monthly there after until substantial compliance is achieved. Results will be brought to regularly scheduled QAPI meetings.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented (- 08/27/2026)

132e Fire Drill Sleeping Hours

8. Requirements

2600.
132.e. A fire drill shall be held during sleeping hours once every 6 months.

Description of Violation

The home's most recent sleeping hours fire drill was held on 8/1/25 at 6:15 a.m.

132e - Fire Drill Sleeping Hours *(continued)*

Plan of Correction ***Accept ([redacted] - 08/13/2026)***

On 2/23/2026 the facility believed that the sleeping hour fire drill that was conducted at 9:35pm was within the regulatory requirement, no other drill had been conducted. Facilities manager has been educated by the administrator on the proper time frames of a sleeping hour fire drill on 06/10/2026. A fire drill was conducted on 7/12/2026 during the 10pm to 6:30am shift with only 2 staff present whereby the 10-minute evacuation requirement was met and all residents were safely evacuated. The administrator/designee will audit the 6-month sleeping hour drill monthly to validate compliance. Results will be brought to regularly scheduled QAPI meetings.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented ([redacted] - 08/27/2026)

132g - Fire Drills Days/Times

9. Requirements

2600.
132.g. Fire drills shall be held on different days of the week, at different times of the day and night, not routinely held when additional staff persons are present and not routinely held at times when resident attendance is low.

Description of Violation

The home routinely holds fire drills when there are additional staff on the campus that can assist. The home schedules no more than 4 staff per waking hours shift, and no more than 2 staff during sleeping hours. On 7/10/25 at 3:27 p.m. the home used 6 staff to evacuate the residents. On 8/1/25 at 6:15 a.m. the home used 9 staff to evacuate the residents. On 9/30/25 at 8:42 a.m. the home utilized 5 staff to evacuate the residents. On 10/30/25 at 8:00 p.m. the home used 8 staff to evacuate the residents. On 11/25/25 at 12:30 p.m. the home used 10 staff to evacuate the residents. On 12/22/25 at 3:15 p.m. the home used 9 staff to evacuate the residents. On 1/30/26 at 4:30 p.m. the home used 7 staff to evacuate the residents. On 2/23/26 at 9:35 p.m. the home used 5 staff to evacuate the residents. On 3/24/26 at 10:45 a.m. the home used 7 staff to evacuate the residents. On 4/30/26 at 12:45 p.m. the home used 8 staff to evacuate the residents. On 5/5/26 at 8:30 a.m. the home used 7 staff to evacuate the residents.

Plan of Correction ***Accept ([redacted] - 08/13/2026)***

Facility fire drills will be conducted according to the regulations. Facilities manager has been educated by the administrator on the proper days and times of fire drills on 06/10/2026. A fire drill was conducted by the Facilities Manager on 7/12/2026 during the 10pm to 6:30 am shift with 2 overnight staff present. The 10-minute evacuation requirement was met and all residents were safely evacuated. The administrator/designee will audit the fire drill times and days monthly and results will be brought to regularly scheduled QAPI meetings

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented ([redacted] - 08/27/2026)

185a - Implement Storage Procedures

10. Requirements

2600.
185.a. The home shall develop and implement procedures for the safe storage, access, security, distribution and use of medications and medical equipment by trained staff persons.

185a - Implement Storage Procedures *(continued)*

Description of Violation

Resident #4 has an order for their blood glucose to be tested 4 times a day. The resident utilizes a Dexcom. There was no log available to review to ensure the numbers were transcribed correctly.

At 2:45 p.m. five oxygen tanks were observed being stored directly on the floor of resident room 52. The oxygen tanks were not secured to the wall or stored in stands to prevent tipping over.

Plan of Correction ***Accept (- 08/13/2026)***

Resident # 4 Dexacom results were reviewed and validated that they appeared in the medical record by the director of nursing on 6/15/2026. No other residents were found to be out of compliance. Resident room 52 oxygen tanks were secured on 06/10/2026 by the Lead Medication Technician and no other rooms found to be out of compliance. Nursing staff was educated by director of nursing on 07/29/2026 regarding the transcription of Dexacom results and how to obtain logs. Staff educated by the Lead Medication Technician on 06/10/2026 & 6/17/2026 on proper oxygen storage. An audit of all resident records was conducted by director of nursing on 06/15/2026 for a missing dexacom results and dexacom logs. An audit of all resident rooms was conducted on 06/10/2026 for safe oxygen storage. The facilities manager &/or designee will audit resident rooms for safe oxygen storage monthly until substantial compliance is achieved. Results will be brought to regularly scheduled QAPI meetings. The director of nursing &/or designee will audit all residents with Dexacom for transcription into record and available logs monthly thereafter until substantial compliance is achieved. Results will be brought to regularly scheduled QAPI meetings.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented (- 08/27/2026)

187a - Medication Record

11. Requirements

2600.
187.a. A medication record shall be kept to include the following for each resident for whom medications are administered:
3. Name of medication.

Description of Violation

Resident #3's Medication Administration Record (MAR) indicates Thiamine HCl Oral 100 mg tablet, take 1 tablet by mouth 1 time a day. The medication package indicates Vitamin B1, 100 mg tablet, take 1 tablet by mouth 1 time a day. The medication package does not match the MAR.

Plan of Correction ***Accept (- 08/13/2026)***

Resident #3's medication profile was reviewed and updated as necessary on 6/10/2026 by the Director of Nursing. Nursing staff was educated on 06/17/2026 & 07/29/2026 by the director of nursing on how to identify the medication description from PCC to the packaging. A random audit of the current residents' orders was conducted by 7/27/2026 & 7/31/2026 by Director of Nursing to validate medication orders match the packaging. The director of nursing/designee will audit all new orders for medication orders matching the packaging weekly for 3 months and then monthly until substantial compliance has been achieved. Results will be brought to regularly scheduled QAPI meetings.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented (- 08/27/2026)

187b - Date/Time of Medication Admin.

12. Requirements

2600.
187.b. The information in subsection (a)(13) and (14) shall be recorded at the time the medication is administered.

Description of Violation

Resident #2 is prescribed Prednisone 5mg, one tablet one time a day. Resident #2 was also prescribed Prednisone 5mg, two tablets a day on 6/4/26, 6/5/26, and 6/6/26 and three tablets a day on 6/1/26, 6/2/26, and 6/3/26. Resident #2 stores the medication in their room and self-administers the medication. From 6/1/26 through 6/11/26 the medication was initialed as administered by staff at 8:00 a.m. on the medication administration record.

Plan of Correction ***Accept (- 08/13/2026)***

Resident # 2 order was updated to indicate unsupervised self-administration on 06/10/2026 by the Director of Nursing. Staff education was conducted on 6/17/2026 by the director of nursing on the proper completion of the "administered by" section of the order in the Point Click Care EMR system. An audit was conducted on 6/17/2026 by the Director of Nursing for the accuracy of residents who self-administer on the "Administered by" section of the order. The director of nursing/designee will audit all new orders for the proper completion of the "administered by" section of the order in Point Click care weekly for 3 months, then monthly for 3 months and then ongoingly until substantial compliance has been achieved. Results will be brought to regularly scheduled QAPI meetings.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented (- 08/27/2026)

225c - Additional Assessment

13. Requirements

2600.
225.c. The resident shall have additional assessments as follows:
2. If the condition of the resident significantly changes prior to the annual assessment.

Description of Violation

Resident #5 requires a hospital bed with side rails as ordered by Hospice care. Resident #5 also requires an assist of two persons for transfers in the event of an emergency evacuation. The assessment dated for resident #5 does not include the need for the hospital bed or the need for a two person assist for emergency transfers.

Resident #6's diet order was changed on to mechanical soft/Advanced chopped texture. Resident #6's assessment dated indicates no dietary needs on page 7.

Repeated violation 9/18/25 and 6/10/25.

225c Additional Assessment *(continued)*

Plan of Correction ***Accept ([redacted] - 08/13/2026)***

Resident # 5 is no longer in the facility, Resident #5's RASP was reviewed to validate the accuracy of the RASP regarding appropriate equipment and transfer need on 6/11/2026 by the Director of nursing. Resident #6's RASP was updated on 4/28/2026 by the Director of Nursing and reviewed for accuracy on 6/11/2026. Nursing Leaders were educated by the Administrator on 06/23/2026 on accuracy of RASP updates. An audit of the equipment, transfers & diets for current residents RASPs will be conducted by the director of nursing &/or designee by 8/4/2026 for accuracy of RASP. The Director of Nursing will review current residents' RASP for accuracy monthly for 3 months and ongoingly until substantial compliance has been achieved. Results will be brought to regularly scheduled QAPI meetings.

Licensee's Proposed Overall Completion Date: *08/04/2026*

Implemented ([redacted] - 08/27/2026)